Certificate of Medical Necessity
17 Alpha-Hydroxyprogesterone (17-P)
Mississippi Medicaid

Patient Information:
Patient Name: _____ Date of Birth _____
Medicaid # _____ Phone # _____

Physician Information:
Physician Name _____ Physician Medicaid ID # _____
Specialty _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____ Fax ( ) _____

Compliance with all of the criteria listed in Policy section 56.05 is a condition for payment for this drug by Mississippi Medicaid. To assist the fiscal agent in determining whether the drug is covered, the following questions must be completed by the physician and submitted to the fiscal agent's Medical Review Unit.

What is the current gestational age in weeks?_____ Expected date of delivery?_____

YES	NO	
☐	☐	Does the patient have a history of spontaneous prior pre-term birth in a singleton pregnancy, with or without shortened cervix, that was not an indicated delivery for obstetric, infectious or medical disorder/pre-eclampsia reason(s)? If yes, provide the gestational age(s) in weeks of the prior spontaneous preterm birth(s): _____

OR

☐	☐	Does the patient have a singleton gestation and a shortened cervix as demonstrated by vaginal ultrasound (≥ 5 mm but ≤ 25 mm 18 – 34 weeks)?
☐	☐	Has the patient been taught the signs and symptoms of pre-term labor and what to do if she experiences any of the signs and symptoms?
☐	☐	Has the patient agreed to take 17-P injections and agreed to be compliant with the treatment program?
☐	☐	Does the patient have any of the contraindications listed in the Division of Medicaid's policy section 56.05? If yes, identify: _____

Physician Signature: _____ Date: _____
(By signature, the physician confirms the information above is accurate and verifiable in the patient records.)

Mail or fax the Certificate of Medical Necessity to the fiscal agent:

ACS
Attn: Medical Review
P. O. Box 23080
Jackson, MS 39225

OR

Fax #: 601–206–3119
Attention: Medical Review